OCCUPATIONAL MEDICAL SURVEILLANCE PROGRAM
OCCUPATIONAL/MEDICAL QUESTIONNAIRE

(See Form ARS-182A/B for Privacy Act Notification)

DEMOGRAPHIC INFORMATION

LAST NAME	FIRST NAME	MIDDLE NAME

SOCIAL SECURITY NUMBER	DATE OF BIRTH *(mm/dd/yyyy)*	SEX
		☐ MALE ☐ FEMALE

RACE

- ☐ BLACK/NOT HISPANIC ORIGIN
- ☐ WHITE/NOT HISPANIC ORIGIN
- ☐ HISPANIC
- ☐ ASIAN/PACIFIC ISLANDER
- ☐ AMERICAN INDIAN/ ALASKAN NATIVE
- ☐ OTHER *(specify):*

MARITAL STATUS

- ☐ SINGLE/NEVER MARRIED
- ☐ MARRIED/LIVING TOGETHER
- ☐ SEPARATED
- ☐ DIVORCED
- ☐ WIDOWED

EMPLOYEE'S MAILING ADDRESS *(Where confidential mail can be delivered)*

STREET	APARTMENT NO.	
CITY	**STATE**	**ZIP CODE**

EMPLOYEE'S PHYSICIAN

LAST NAME	OFFICE TELEPHONE *(Include Area Code)*	
STREET ADDRESS	**SUITE NO.**	
CITY	**STATE**	**ZIP CODE**

EMPLOYEE'S CURRENT JOB

LOCATION *(City)*	STATE	ZIP CODE
REGULAR WORKPLACE *(Building and Room No.)*		**GS SERIES**
JOB TITLE		**YEARS IN PRESENT JOB**

Have you ever been a resident outside the United States? ☐ No ☐ Yes

If yes, please list the location(s) and date(s).	FROM MONTH/YEAR	TO MONTH/YEAR
1.		
2.		
3.		
4.		
5.		
6.		

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EMPLOYMENT HISTORY

Start with the job you held before this one, and list **all** the jobs you ever had. Include military service and any part-time jobs.

COMPANY NAME OR TYPE OF BUSINESS	FROM MONTH/YEAR	TO MONTH/YEAR	JOB TITLE OR DESCRIPTION

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RECREATIONAL HISTORY

(Please print)

Do you now or have you in the past, done any of the following as a hobby or during your spare time?	NO	PRE-VIOUSLY	CUR-RENTLY
Auto mechanic work			
Auto body work			
Been exposed to rubber cement for extended periods of time			
Carpentry			
Ceramics			
Etching/metal work/jewelry/metal sculpture			
Furniture refinishing			
House painting			
Lawn/Garden maintenance or farming			
Make your own cartridges/salvage spent cartridges			
Make your own fishing sinkers			
Oil painting			
Pottery			
Recreational hunting/shooting			

Do you now or have you in the past, come into contact with any of the following during your spare time?	NO	PRE-VIOUSLY	CUR-RENTLY
Acids			
Bonding agents or industrial glues			
Cleaning fluids			
Fertilizers			
Gasoline or other petroleum products			
Herbicides or weed killers			
Insecticides/pesticides			
Insulation material			
Lacquer, varnish or enamel paints			
Leather dyes			
Paint thinners and removers			
Soldering agents			
Solvents/degreasers			
Wood stains			

In your work are you now or have you been exposed to any of the following agents?

	PRE-SENT	PAST		PRE-SENT	PAST		PRE-SENT	PAST
Inorganic flourides			Excessive noise			Asbestos		
Lead			Nitrogen oxides			Suspect or known carcinogens		
Benzene			Crystalline silica			Pesticides		
Coke oven emissions			Nitric acid			Bacteria or viruses		
Inorganic arsenic			Ammonia			Primate animals		
Methylene chloride			Beryllium			Vibrating tools		
Vinyl chloride			Phosgene			Radiation *(Ionizing)*		
Toluene diisocyanate			Allyl chloride			Radiation *(Non-Ionizing)*		

Please make a list of those substances that you handle in your work. **Star (*)** those that particularly concern you from a health standpoint.

Indicate any symptoms that you have experienced that might be due to exposure at work and indicate the suspected cause.

SYMPTOM: **CAUSE:**

Have you experienced any **job related** illnesses or injuries since being employed by the USDA? ☐ No ☐ Yes

IF YES, GIVE DETAILS: **MONTH AND YEAR:**

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SMOKING HISTORY

CIGARETTES: Have you ever smoked cigarettes regularly?

☐ No ☐ Yes *(If yes, please answer the following questions.)*

("No" means never smoked, or smoked less than 20 packs of cigarettes or 12 ozs. of tobacco in life-time, or less than 1 cigarette a day for one year.)

a. How old were you when you started smoking cigarettes regularly? ____ Years

b. Do you still smoke cigarettes? ☐ No ☐ Yes
If yes, how many cigarettes do you now smoke per day? ____ Cig./da

c. If you have stopped smoking cigarettes, how old were you when you stopped? ____ Years

d. On the average, of the entire time you have smoked, how many cigarettes did you smoke per day? ____ Cig./da

e. Do, or did you inhale the cigarette smoke? ☐ No ☐ Yes

PIPES: Have you ever smoked a pipe regularly?

☐ No ☐ Yes *(If yes, please answer the following questions.)*

("No" means never smoked, or smoked no more than 12 ozs. of pipe tobacco in your life-time.)

a. How old were you when you started smoking pipes regularly? ____ Years

b. Do you still smoke pipes? ☐ No ☐ Yes
If yes, how many ounces of pipe tobacco do you now smoke per week? ____ Ozs./week

c. If you have stopped smoking a pipe, how old were you when you stopped? ____ Years

d. On the average, of the entire time you have smoked, how many ounces of tobacco did you smoke per day? ____ Ozs./week

e. Do, or did you inhale the pipe smoke? ☐ No ☐ Yes

CIGARS: Have you ever smoked cigars regularly?

☐ No ☐ Yes *(If yes, please answer the following questions.)*

("No" means never smoked, or smoked no more than 1 cigar a week for 1 entire year.)

a. How old were you when you started smoking cigars regularly? ____ Years

b. Do you still smoke cigars? ☐ No ☐ Yes
If yes, how many cigars do you now smoke per day? ____ Cigars/day

c. If you have stopped smoking cigars, how old were you when you stopped? ____ Years

d. On the average, of the entire time you have smoked cigars, how many cigars did you smoke per day? ____ Cigars/day

e. Do, or did you inhale the cigar smoke? ☐ No ☐ Yes

TOBACCO CHEWING: Have you ever chewed tobacco regularly?

☐ No ☐ Yes *(If yes, please answer the following questions.)*

a. How old were you when you started chewing tobacco regularly? ____ Years

b. Do you still chew tobacco? ☐ No ☐ Yes

c. If you have stopped chewing tobacco, how old were you when you stopped? ____ Years

SNUFF: Have you ever used snuff regularly?

☐ No ☐ Yes *(If yes, please answer the following questions.)*

a. How old were you when you started using snuff regularly? ____ Years

b. Do you still use snuff? ☐ No ☐ Yes

c. If you have stopped using snuff, how old were you when you stopped? ____ Years

LIFE-STYLE HISTORY

ALCOHOLIC BEVERAGES: Do you now or have you ever drunk alcoholic beverages (such as wine, beer, or hard liquor) regularly?

☐ No ☐ Yes *(If yes, please answer the following questions.)*

a. Which of the following do you regularly drink? *(Check all that apply.)*
☐ Wine
☐ Beer
☐ Liquor

b. Have you stopped drinking regularly? ☐ No ☐ Yes
If yes, how many years ago did you stop? ____ Years

c. How much do (did) you drink on an average day or in an average week?

☐ Less than 1 drink per day, or less than 7 drinks per week.

☐ 1 to 2 drinks per day, or 7 to 17 drinks per week.

☐ 3 to 4 drinks per day, or 18 to 31 drinks per week.

☐ 5 or more drinks per day, or more than 31 drinks per week.

EXERCISE: Do you get exercise on a regular basis?

☐ No ☐ Yes *(If yes, please answer the following questions.)*

a. How many days per week? ____ Days/week

b. How many minutes do you exercise? ____ Minutes

c. Describe the kind of exercise you get:

DIET:

a. Do you drink more than two cups of coffee or tea a day? ☐ No ☐ Yes

b. Do you restrict your diet? *(If yes, which of the following items do you restrict?)* ☐ No ☐ Yes

☐ Meat ☐ Sodium or Salt
☐ Sugar ☐ Foods high in cholesterol
☐ Other *(describe):*

c. How many years have you been restricting your diet? ____ Years

d. Why are you restricting your diet?

☐ Religious reasons ☐ Medical reasons
☐ Other *(describe):*

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MEDICAL HISTORY

CARDIOVASCULAR: Have you ever had or do you now have any of the following illnesses or problems with your heart or blood vessels?

	NO	YES PAST	YES CURRENT
Heart Attack			
Angina Pectoris			
Heart Murmur			
Enlarged Heart			
Stroke			
High Blood Pressure			
Other problems with blood pressure			
Episodes of chest pains, tightness, discomfort			
Rheumatic Heart Disease			
Arteriosclerosis			
Varicose Veins			
Other *(specify):*			
Have you ever had heart surgery? *(If yes,*			

RESPIRATORY ILLNESS/CONDITIONS: Have you had or do you now have any of the following illnesses or problems with your lungs?

	NO	YES PAST	YES CURRENT
Frequent Colds			
Coughed up Blood			
Chronic Cough			
Lung or Breathing difficulties or Shortness of Breath			
Asthma			
Emphysema			
Pneumonia			
Tuberculosis			
Bronchitis			
Pleurisy			
Other *(specify):*			
Have you ever had surgery on your lungs? *(If yes. describe):*			

Have you ever had or do you now have any of the following problems with your mouth, nose or throat?

	NO	YES PAST	YES CURRENT
Nasal passages frequently irritated			
Nose Bleeds often			
Throat is often irritated			
Voice is hoarse when you do not have a cold			
Mouth/Gums frequently have sores/ulcers			
Gums shrinking, irritated or bleeding			
Other *(specify):*			

ENDOCRINE: Have you ever had or do you now have any of the following illnesses or conditions?

	NO	YES PAST	YES CURRENT
Hypoglycemia			
Diabetes			
Goiter			
Thyroid disease or disorder			
Swollen glands or nodes			
Pancreatitis			
Other gland problems *(specify):*			

DIGESTIVE SYSTEM: Have you ever had or do you now have any of the following illnesses or problems with your digestive system?

	NO	YES PAST	YES CURRENT
Blood in stool			
Stomach or Duodenal Ulcer			
Appendicitis			
Nervous stomach			
Colitis			
Frequent constipation			
Frequent diarrhea			
Frequent indigestion			
Stomach pain			
Hiatal hernia or rupture			
Diverticulitis			
Hemorrhoids or piles			
Other *(specify):*			
system? *(If yes, describe):*			

LIVER AND SPLEEN: Have you ever or do you now have any of the following illnesses or problems with your liver, spleen, or gallbladder?

	NO	YES PAST	YES CURRENT
Cirrhosis of the liver			
Hepatitis			
Jaundice			
Gallbladder disease			
Gallbladder stones			
Injury to your spleen			
Other *(specify):*			
Have you ever had surgery on your liver or spleen? (*If yes, describe):*			

KIDNEYS/URINARY TRACT: Have you ever had or do you now have any of the following illnesses or problems with your kidneys or urinary tract?

	NO	YES PAST	YES CURRENT
Blood in urine			
Pain or burning when urinating			
Kidney disease			
Kidney infection			
Kidney stones			
Nephritis *(Bright's Disease)*			
Bladder Infection			
Prostate gland enlargement/infection *(Males only)*			
Tumor in urinary tract			
Other *(specify):*			
Have you ever had surgery on your kidneys or urinary tract? *(If yes, describe):*			

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MEDICAL HISTORY *(Continued)*

REPRODUCTIVE HISTORY *(please answer all four questions):*

a. Have you or your partner ever had a problem conceiving a child? ☐ Yes ☐ No

If yes, ☐ Self ☐ Present Partner ☐ Previous Partner

b. Have you or your partner consulted a physician for a fertility or other reproductive problem? ☐ Yes ☐ No

If yes, specify who consulted the physician:

☐ Self ☐ Partner ☐ Self and Partner

If yes, specify the diagnosis:

c. Have you or your partner ever conceived a child resulting in a miscarriage, still birth or ☐ Yes ☐ No

If yes, ☐ Miscarriage ☐ Still Birth ☐ Deformed Offspring

If outcome was a deformed offspring, what was the deformity?

Was this outcome a result of a pregnancy of yours with:

☐ Present Partner ☐ A Prior Partner

d. Did the timing of any abnormal pregnancy outcome coincide with your present employment? ☐ Yes ☐ No

List dates of occurrences:

What is the occupation of your partner?

NERVOUS SYSTEM: Have you ever had or do you now have any of the following illnesses or problems with your nervous system?

	NO	YES PAST	YES CURRENT
Frequent headaches			
Migraine headaches			
Epilepsy, convulsions, seizures			
Nervous breakdown			
Depression/Excessive worry			
Loss of memory *(amnesia)*			
Nervousness			
Tremor of the hands or head			
Palsey or tremors			
Severe head injury			
Neuritis			
Paralysis of any type			
Other problems *(specify):*			

BLOOD: Have you ever had or do you now have any of the following blood diseases or problems?

	NO	YES PAST	YES CURRENT
Anemia			
Low hemoglobin			
Bleeding disorder			
Leukemia			
Sickle cell disease or trait			
Phlebitis			
Other problems *(specify):*			
Have you ever had a blood transfusion?			

BONES AND JOINTS: Have you ever had or do you now have any of the following problems with your bones or joints?

	NO	YES PAST	YES CURRENT
Arthritis or Rheumatism			
Gout			
Joint pains			
Bone infections			
Bursitis or tendonitis			
Backache, back trouble, sciatica			
Foot trouble, flat feet or fallen arches			
"Trick", "locked", or "loose" knee			
Back injury or herniated disk			
Painful or trick shoulder			
Swollen or painful joints			
Other problems with your bones or joints *(If yes, specify):*			

Have you ever had surgery *(including setting of broken bones)* on any of your bones or joints? *(If yes, describe):*

SKIN: Have you ever had or do you now have any of the following skin

	NO	YES PAST	YES CURRENT
Hives			
Eczema			
Psoriasis			
Rash on elbows, knees, or scalp			
Rash other than on elbows, knees, or scalp			
Severe stubborn dandruff			
Small itching blisters on the sides of your fingers or palms			
Excessive sweating on palms, soles, or armpits			
Sores that do not heal			
Moles that bleed or get larger			
Change in color of skin *(other than suntan)*			
New growth on skin			
Other *(If yes, describe):*			

ALLERGIES: Have you ever had or do you now have any allergies?

	NO	YES PAST	YES CURRENT
Medications *(If yes, please list):*			

	NO	YES PAST	YES CURRENT
Food			
Soaps or detergents			
Chromium			
Nickel			
Rubber			
Epoxy resins			
Plants *(e.g., poison ivy, etc.)*			
Pollen			
Insect scales			
Bee stings			

(NOTE: This section continues at top of next page.)

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MEDICAL HISTORY *(Continued)*

ALLERGIES *(Continued)*

	NO	YES PAST	YES CURRENT
House dust			
Animal dander, feathers, or fur			
Sunlight or cold			
Other *(If yes, please list):*			
Do you react with: Rash			
Hives			
Hay fever symptoms			
Breathing difficulty			
Other *(If yes, describe):*			

EARS: Have you ever had or do you now have any of the following problems with your ears or your hearing?

	NO	YES PAST	YES CURRENT
Difficulty in hearing			
Tinnitus *(ringing/buzzing)* in right ear			
in left ear			
Nasal allergy			
Vertigo *(dizziness)*			
Perforation of the ear drum			
Ear drainage *(caused by infection or injury)*			
High fever			
Infection of inner ear			
Hearing loss by blood relatives *(such as grandparents, parents, aunts, uncles, brothers, or sisters)* before they reached the age of 60			
Other problems with your ears *(If yes, describe):*			

EYES: Have you ever had or do you now have any of the following problems with your eyes or your vision?

	NO	YES PAST	YES CURRENT
Glaucoma			
Cataracts			
Conjunctivitis *(pink eye)*			
Blurring of eyesight			
Vision getting worse			
Seeing double			
Seeing halos around lights			
Pain in the eyeball			
Eyes are often bloodshot			
Right eye / Left eye — Injured (e.g., scratched, burned, cut, etc.)			
Right eye / Left eye — Foreign object accidentally embedded in the eye			
Other problems with your eyes *(If yes, describe):*			
Do you wear glasses?			
Do you wear contact lenses?			

CANCER: Have you ever been diagnosed with cancer?
☐ No ☐ Yes *(If yes, list the year and type of diagnosis.)*

Type	Year	Specific Tissue Diagnosis *(If available)*
Skin		
Colon		
Breast		
Lung		
Prostate		
Cervical		

Other *(If yes, specify type and describe tissue diagnosis and year)*:

INFECTIOUS/CHILDHOOD DISEASES: Have you had or do you now have:

	NO	YES PAST	YES CURRENT
Mononucleosis			
Meningitis			
Malaria			
Polio			
Rheumatic fever			
Scarlet fever			
Mumps			
Measles			
Chicken pox			
German measles			
Tonsillitis			
Gonorrhea			
Syphilis			

FAMILY HISTORY: Have any of your blood relatives *(parents, grandparents, brothers, sisters, aunts, uncles or children)* had any of the following illnesses or conditions?

	NO	YES PAST	YES CURRENT
Anemia			
Alcoholism			
Allergies			
Arthritis			
Asthma			
Bleeding disorders *(free bleeder)*			
Breast cancer			
Cervical cancer			
Chronic bronchitis			
Congenital malformations *(birth defect)*			
Diabetes *(sugar)*			
Digestive or bowel disease			
Eczema			
Emphysema			
Epilepsy			
Glaucoma			
Gout			
Hay fever			
Heart attack			
Heart disease			
High blood pressure			
Kidney or bladder disease			
Kidney stones			
Liver or gallbladder disease			
Lung cancer			
Mental illness			
Mental retardation			
Nervous system disease			
Psoriasis			

(NOTE: This section continues at top of next page.)

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MEDICAL HISTORY *(Continued)*

FAMILY HISTORY *(Continued)*

	NO	YES PAST	YES CURRENT
Sickle cell disease or trait			
Stroke			
Thyroid disease			
Tuberculosis *(T.B.)*			
Ulcer *(stomach, duodenal, peptic)*			
Other cancers or leukemia			

Is your mother still living? ☐ No ☐ Yes

If not, please give age at death: ____ Years

and cause of death:

Is your father still living? ☐ No ☐ Yes

If not, please give age at death: ____ Years

and cause of death:

Are you aware of any disease or illnesses that run in your family? *(If yes, please list below):* ☐ No ☐ Yes

MEDICATIONS: Have you taken any of the following medications in the last

	NO	YES PAST	YES CURRENT
Antacids			
Antibiotics *(e.g., penicillin, ampicillin, tetracycline)*			
Antihistamines			
Aspirin			
Benzedrine / Dexedrine			
Birth control pills			
Blood thinners *(anti-coagulants)*			
Codeine			
Cortisone or other steroids			
Diet pills			
Digitalis or other heart pills			
Diuretic or water pills			
Hormones			
Insulin or oral anti-diabetic drugs			
Iron pills			
Laxatives			
Morphine			
Nitroglycerine			
Pain killers *(aspirin, empirin, anacin, bufferin, etc.)*			
Pep pills or Mood elevators			
Pills to lower your blood pressure			
Sleeping pills			
Sulfa preparations			
Thyroid medication			
Tranquilizers, sedatives, or nerve pills			
Vitamins			
Others			

IMMUNIZATIONS, VACCINES, ANTITOXINS: If you have received any of the following, check the appropriate box(es) and give the approximate dates, if known.

	Date *(mm/dd/yyyy)*
☐ Tetanus	
☐ Poliomelitis	
☐ Influenza	
☐ Typhoid	
☐ Diptheria	
☐ Rabies	
☐ Rubella *(German measles)*	
☐ Measles *(Rubeola or red measles)*	
☐ BCG	
☐ Yellow Fever	
☐ Smallpox	
☐ RhoGAM *(Rh immune globulin)*	
☐ Immune serum globulin for hepatitis	
☐ Others *(please list):*	
☐ Mantoux, patch test, or other skin test for tuberculosis	
Results: ☐ Positive ☐ Negative	

HISTORY OF HOSPITALIZATION: Have you ever been hospitalized?

☐ No ☐ Yes *(If yes, list reason(s) and date(s) of hospitalization.)*

Do you have any problems you would like to discuss with the doctor?

☐ No ☐ Yes *(If yes, please list them):*

SIGNATURE AND DATE COMPLETED

(Mo.) (Day) (Yr.)